CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MCAP CHANGE IN STATUS FORM
for FY_____

Section 1 – Employee Information

_____	_____	_____	_____
Social Security Number	*Last Name*	*First*	*Initial*

Section 2 – Complete the section which applies to your requested change.

A Change in Status which is **on account of and consistent with the nature of the qualifying event** must occur in order to change your current MCAP account. Requests to change your deduction amount or revoke your enrollment must be initiated within 60 days of the qualifying event. Changes in Status indicated with an '*' must be reviewed and approved by the FSA Unit on a case-by-case basis. You may contact the FSA Unit at 1-800-442-1300 if you have any questions.

☐ **Increase in Deduction Amount** **Change in Status Code** _____ **New Deduction Amount Per Pay Period** $_____

01	Birth or adoption of dependent
02	Marriage
03	Divorce, legal separation or annulment *
07	Change of county of residence/worksite for employee or spouse *

08	Judgment, decree or court order *
15	Spouse or dependent terminates employment
17	Spouse or dependent changes employment status from Full-time to Part-time
20	Spouse enters leave of absence and loses FSA enrollment
24	Coordination of spouse's annual benefit election period

☐ **Decrease in Deduction Amount** **Change in Status Code** _____ **New Deduction Amount Per Pay Period** $_____

03	Divorce, legal separation or annulment *
04	Death of dependent or spouse
05	Dependent becomes ineligible
06	Dependent becomes eligible for coverage
07	Change of county of residence/worksite for employee or spouse *

08	Judgment, decree or court order *
09	Entitlement to Medicare or Medicaid
14	Spouse or dependent commences employment
18	Spouse or dependent changes employment status from Part-time to Full-time
20	Spouse enters leave of absence and loses FSA enrollment
24	Coordination of spouse's annual benefit election period

☐ **Revocation of Enrollment** **Change in Status Code** _____

03	Divorce, legal separation or annulment *
04	Death of dependent or spouse
05	Dependent becomes ineligible
08	Judgment, decree or court order *
09	Entitlement to Medicare or Medicaid

12	Employee changes employment status from Full-time to Part-time working less than 50%
19	Employee enters leave of absence
22	Employee termination of employment, retirement or death
24	Coordination of spouse's annual benefit election period

Section 3 – Certification

I certify that the above eligible change in status event occurred on _____/_____/_____.

Employee Signature: _____ **Date** _____/_____/_____

Section 4 – Agency Approval (To be completed by Group Insurance Representative)

GIR Signature: _____ Date: _____/_____/_____

GIR INSTRUCTIONS	• Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

Return the completed form to your Group Insurance Representative